STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	12/02/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PLACE AT FALL CREEK LLC	5011 KESSLER BLVD E INDIANAPOLIS, IN 46220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R000000	This visit was for a Post Survey Revisit (PSR) to the State Residential Licensure Survey, completed on October 17th, 2013. Survey date: December 2, 2013 Facility number: 010064 Provider number: 010064 AIM number: N/A Survey team: Beth Walsh, RN, TC Courtney, Mujic, RN Karina Gates, Generalist Tom Stauss, RN Census bed type: Residential: 53 Total: 53 Census payor type: Other: 53 Total: 53 Sample: 5 These state findings are cited in accordance with 410 IAC 16.2. Quality review completed on December 8, 2013, by Janelyn Kulik, RN.	R000000	The following is the plan of correction for Brookdale Place at Fall Creek in regard to the statement of deficiencies for the annual survey completed on December 2, 2013. This plan of correction is not to be construed as an admission of or agreement with the findings or conclusions in the statement of deficiencies or any related sanctions or fine. Rather it is submitted as a confirmation of our on going efforts to comply with statuatory and regulatory compliance. In this doucment we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvements to satisfy that objective.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	12/02/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PLACE AT FALL CREEK LLC	5011 KESSLER BLVD E INDIANAPOLIS, IN 46220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	12/02/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PLACE AT FALL CREEK LLC	5011 KESSLER BLVD E INDIANAPOLIS, IN 46220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R000091	410 IAC 16.2-5-1.3(h)(1-4) Administration and Management - Noncompliance (h) The facility shall establish and implement a written policy manual to ensure that resident care and facility objectives are attained, to include the following: (1) The range of services offered. (2) Residents' rights. (3) Personnel administration. (4) Facility operations. The policies shall be made available to residents upon request. Based on observation, interview, and record review, the facility failed to implement their medication administration policy for 2 of 5 residents observed during medication administration. (Resident #'s 38 and 47.) Findings include: 1. An observation of LPN #1, on 12/2/2013 at 12:30 pm, indicated Resident #38 was sitting at a table in the 3rd floor dementia unit dining room and two other residents were sitting at the same table. Resident #38 was handed a cup of liquid medication and instructed by LPN #1 to "swish the medication in your mouth and then spit it out into this cup." 2. An observation of LPN #1, on 12/2/2013 at 12:34 pm, indicated	R000091	Corrective action for residents found to have been affected by the deficient practice:Employee, LPN#1 was subject to a corrective action event defining resident rights to privacy, resident dignity and proper procedure for medication pass and observation. The two residents involved received no ill effects from the incident. How the facility identified other residents with potential to be affected by the same practice:All residents receiving medications on the Memory Care Unit had potential to be affected by the practice. Methods put in place to ensure that the deficient practice does not recur:The Health and Wellness Director will perform a medication administration skills check with each licensed nurse and QMA to assure that all staff thoroughly understand the proper procedure for medication administration. These will be documented and completed by January 17, 2014. How will the	01/17/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	12/02/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PLACE AT FALL CREEK LLC	5011 KESSLER BLVD E INDIANAPOLIS, IN 46220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Resident #47 was sitting at a table in the 3rd floor dementia unit dining room. LPN #1 handed a cup with one pill inside to Resident #47. Resident #47 poured the pill into his hand. LPN #1 indicated, "Do you have the medication in your hand?" Resident #47 indicated, "Yes." LPN #1 then walked away, and her back was to the resident when he was observed to place the pill into his mouth and then picked up a glass of water and took a drink. An interview with the Health and Wellness Director, on 12/2/2013 at 1:28 pm, indicated the nurse should have waited to ensure a resident swallows a medication before walking away-they could pocket it or drop it. She indicated a "swish and spit medication should never be given in the dining room." She also indicated the Medication Pass Policy was just recently reviewed with the nursing staff. A document, provided by the Health and Wellness Director, on 12/2/2013 at 1:05 pm, indicated, "All nurse's must review and sign off. Training Attendance Form. Course Name: Nurse Review Medication Pass. Date: 11/1/2013- 12/1/2013." LPN #1's signature was listed as the #1		corrective actions be monitored to ensure the practice will not recur:The health and Wellness Director will monitor the medication administration process which occurs primarily on the first and second shifts by random weekly observations of medication administration, correcting any non compliant practices she finds. The HWD will bring the results of these medication administration checks to the QA committee who will review them on a monthly basis. The QA committee will continue to monitor these checks until three full months of compliance are achieved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	12/02/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PLACE AT FALL CREEK LLC	5011 KESSLER BLVD E INDIANAPOLIS, IN 46220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	attendee. A policy, provided by the Health and Wellness Director, on 12/2/2013 at 12:11 pm, indicated, "Policy Name: Medication Pass. Policy Detail: 14. Always observe resident until they have for certain swallowed all medications. 29. Be aware of patient dignity issues when it is time for medication to be given. It is generally accepted the following are not to be done in a dining area: injections, eye drops, removal or application of nitro patches, nasal sprays, inhalers, and vital signs." This State Residential tag was cited on 10/17/13. The facility failed to implement a systemic plan of correction to prevent recurrence.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	12/02/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PLACE AT FALL CREEK LLC	5011 KESSLER BLVD E INDIANAPOLIS, IN 46220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R000185	410 IAC 16.2-5-1.6(i)(1-2)(A)(i-iii)(B-E Physical Plant Standards - Noncompliance (i) The facility shall house residents only in areas approved by the director for housing and given a fire clearance by the state fire marshal. The facility shall: (1) Have a floor at or above grade level. A facility whose plans were approved before the effective date of this rule may use rooms below ground level for resident occupancy if the floors are not more than three (3) feet below ground level. (2) Provide each resident the following items upon request at the time of admission: (A) A bed: (i) of appropriate size and height for the resident; (ii) with a clean and comfortable mattress; and (iii) with comfortable bedding appropriate to the temperature of the facility. (B) A bedside cabinet or table with a hard surface and washable top. (C) A cushioned comfortable chair. (D) A bedside lamp. (E) If the resident is bedfast, an adjustable over-the-bed table or other suitable device. (3) Provide cubicle curtains or screens if requested by a resident in a shared room. (4) Provide a method by which each resident may summon a staff person at any time. (5) Equip each resident unit with a door that swings into the room and opens directly into the corridor or common living area. (6) Not house a resident in such a manner as to require passage through the room of another resident. Bedrooms shall not be used as a thoroughfare. (7) Individual closet space. For facilities and additions to facilities for which construction plans are submitted for approval after July 1, 1984, each resident room shall have			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	12/02/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PLACE AT FALL CREEK LLC	5011 KESSLER BLVD E INDIANAPOLIS, IN 46220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	clothing storage that includes a closet at least two (2) feet wide and two (2) feet deep, equipped with an easily opened door and a closet rod at least eighteen (18) inches long of adjustable height to provide access by residents in wheelchairs. Based on observation, interview and record review, the facility failed to ensure residents on the 3rd floor were provided with a system to summons a staff person at any time for 6 of 20 residents on the 3rd floor. (Residents #37, 47, 40, 46, 53, and 35) Findings include: An environmental tour of the 3rd floor of the facility was conducted with the Maintenance Coordinator on 12/2/13 at 11:40 a.m. He indicated the facility's call system was provided by way of the telephones. A staff member assigned to the resident's room carries a portable phone, known as a scout phone, that rings and displays the room number of the resident requesting assistance. The bathroom call light for Resident #37 was pulled in an attempt to test the call system. The scout phone rang once and displayed the room number. After 2 seconds, the room number was no longer displayed on	R000185	Corrective action for residents affected by the practice:When the first issue occurred with the call system, the community called a technician to assure the system was working properly. When he arrived, he performed a System “reset” and assured us the system was working properly. The maintenance technician from Fall Creek performed a check of the system on 11/19/13 and found it to be working properly. When we discovered during the survey that the system was again not operating correctly, we called the district maintenance supervisor who arrived within a few minutes and performed another system ‘reset’ and demonstrated to the surveyors that the system was indeed working properly again.Identify other residents having the potential to be affected by the practice: All residents on the Memory Care Unit have potential to be affected by the practice. Once the unit is repaired, the maintenance tech will perform a check of each resident’s emergency call light to assure every one is working as it should. Measures put in place to assure the practice does not recur:Upon questioning, the original repair	12/13/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	12/02/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PLACE AT FALL CREEK LLC	5011 KESSLER BLVD E INDIANAPOLIS, IN 46220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the screen, and the phone no longer rang after the first ring. No staff member responded to the summons. The 5 bathroom call lights of Residents #47, 40, 46, 53 and 35 were also pulled in an attempt to test the call system. After each attempt, the scout phone rang once and displayed the room number, but after 2 seconds, the room number was no longer displayed on the screen, and the phone no longer rang after the first ring. The Maintenance Director indicated the phone should continue to ring multiple times as well as continue to display the room number. He further indicated if a staff member carried the scout phone in their pocket, as they do, the resident's room number would no longer be displayed on the screen by the time the staff member was able to look at the phone, rendering them unable to determine which resident was requesting assistance. During an interview with CNA #3 on 12/2/13 at 11:55 a.m., she indicated the second and only other scout phone on the 3rd floor did not ring or display a room number when the above residents' bathroom call lights were tested. At this time, an observation of the second scout phone was made with CNA #3. The		technician stated that a new part for the system would be needed. It was ordered and will be installed at the earliest opportunity.While we await the final repair of the system, and In order to assure the residents on the Memory Care Unit all have an emergency call system that operates correctly, the following plans were put in place on 12/13/13;The Maintenance Tech or a designee will check daily to assure the phone system is working properly by Check that the function is on at the junction box.Check a pull cord on the memory care unit daily to assure the scout phones are reacting correctly Daily documentation of these checks will be turned in to the ED each week and any issues brought to her attention immediately.Memory Care Unit Manager initiated a sign off sheet to assure shift to shift passage of scout phones for monitoring the call system is completed effectively and each direct care staff has a working scout phone in their possession while on duty.Charge nurses will be responsible to assign scout phones to oncoming staff and assure outgoing staff return the phones in proper working order. Daily documentation of these assignments will be turned in to the ED on a weekly basis with immediate notification with any issues with the system. The ED will review these documents	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	12/02/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PLACE AT FALL CREEK LLC	5011 KESSLER BLVD E INDIANAPOLIS, IN 46220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	phone was on the charger, dead. She indicated, "It's been like that for 2 or 3 weeks. Right now, we only have one phone up here (on the 3rd floor)." During another interview with the Maintenance Director on 12/2/13 at 12:05 p.m. he indicated, "(Name of staff person), who takes care of scout phones, has been out for 2 weeks...No one told me the 2nd scout phone wasn't working." He further indicated a new call system would be "safer for the residents." The Life Safety Systems Checklist Monthly Checks was provided by the Maintenance Director on 12/2/13 at 12:05 p.m. It indicated, "Ensure all pull cords; resident room and common areas, are attached and working properly and within reaching distance for use." It indicated this task was last completed on 11/19/13. This State Residential tag was cited on 10/17/13. The facility failed to implement a systemic plan of correction to prevent recurrence.		weekly and take the findings to the Quality Assurance Committee each month. The QA team will monitor the corrective action until 3 months of full compliance are achieved once all system repairs have been completed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	12/02/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PLACE AT FALL CREEK LLC	5011 KESSLER BLVD E INDIANAPOLIS, IN 46220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE